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Barriers Associated with Mental Health Services for People with Refugee Background in Douglas County

Mustapha Barry
University of Nebraska Medical Center

Project Title

Barriers Associated with Mental Health Services for People with Refugee Background in Douglas County

Student Name and Concentration

Mustapha Barry (Public Health Administration and Policy)

University of Nebraska Medical Center

Committee

1- Jungyoon Kim, PhD, Health Policy and Administration

2- Hyo Jung Tak, PhD, Public Policy

3- Jeanette Harder, PhD, Social Work

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Abstract

INTRODUCTION: The United States of America has been one of the leading countries where refugees from all over the world seek safety and security under the refugee resettlement program. Research suggests that refugees underutilize mental health services throughout the United States, despite the higher rates of mental health issues among refugees.

OBJECTIVE: This study explored barriers, support services, and factors associated with mental health services utilization among people with refugee backgrounds in Douglas County, Nebraska.

METHODS: Data from 30 participants were collected through a telephone survey and analyzed to determine participant's level of mental health services utilization, barriers to mental health services, support services, and knowledge of mental health. The data also identified possible solutions to the barriers associated with mental health services for people with refugee background.

RESULTS: Participants came from Asia 77%, Africa 20%, and Europe 3%. There were slightly more males 53% than female 47%. When asked about knowledge of mental health, 81% of males and 79% of females indicated prior knowledge of mental health. However, only 28% reported that they sought mental health services. There was no significant association between knowledge of mental illness and utilization. Age was significantly associated with mental health services utilization.

CONCLUSION: This study provided an opportunity for mental health service providers to improve their services for people with refugee background in Douglas County.

ABBREVIATIONS

United Nations High Commissioner for Refugees …… UNHCR

Catholic Health Initiative……. CHI

Major Depressive Disorder……. MDD

Posttraumatic Stress Disorder …… PTSD

Mental Health and Psychosocial Support ……... MHPSS

Generalized Anxiety Disorder …… GAD 7

Patient Health Questionnaire ……... PHQ 9

Nebraska……NE

ACKNOWLEDGEMENT

I would like to extend my gratitude to the Catholic Health Initiative (CHI) University Campus clinic and the UNMC's college of public health department of administration and policy for giving me the opportunity to contribute to the ongoing effort in addressing health disparity in Nebraska. I am especially thankful to my committee Kim Jungyoon and, Hyo Jung Tak, from the college of public health at UNMC, and Jeanette Harder, from the Grace Abbott School of Social Work at UNO, for their guidance and patience and all the assistance in helping me fulfil the requirements for this capstone project. I would like to thank my supervisor Mandy Leamon and her colleagues at the CHI University Campus clinic for their support in accessing data for the project.

CHAPTER 1 – INTRODUCTION

According to the United Nations High Commissioner for Refugees (UNHCR), a refugee is someone who has been forced to flee his or her country because of persecution, war, or violence. Refugees have a well-founded fear of persecution for reasons of race, religion, nationality, political opinion, or membership in a particular social group. Most likely, they cannot return home or are afraid to do so.

Since the creation of the Refugee Act in 1980, the United States has resettled thousands of people with refugee backgrounds and asylees. According to the U.S. Refugee Agency, 11,814 refugees were admitted across the country in 2020, which marks the least number of people with refugee backgrounds resettled in the United States in decades. Some of those families resettled in Douglas County, Nebraska.

According to the Carnegie Endowment for International Peace, Nebraska had the nation's highest per capita refugee resettlement rate in the fiscal year 2016. From January 2010 to January 2019, the state resettled 8,425 refugees. Over that time span, the top countries of origin for Nebraska-based refugees were Burma/Myanmar (3,755), Bhutan (1,610), and Iraq (1,323).

In the last fiscal year (October 2020 to February 2021) the Catholic Health Initiatives (CHI) provided health screening for 56 new arrivals in Nebraska. Mental health screening was provided for 37 eligible members.

The purpose of this study was to explore some of the factors associated with utilization of mental health services among people with refugee backgrounds in Douglas County, Nebraska. In doing so, this paper will highlight the most significant barriers shown in the literature and

acquire primary data from refugee population in Douglas County for analysis to determine what factors might be associated with the underutilization of mental health services.

CHAPTER 2 – BACKGROUND AND LITERATURE REVIEW

The United States of America is one of the leading countries that provides safety and security to many refugees through the resettlement program. Nebraska is among the states that host the largest number of people with refugee background who are resettled in the country. The Catholic Health Initiative (CHI) is one of the health institutions that screen newly arriving refugees and asylees for physical and mental health.

Upon arrival in the country refugees are administered physical and mental health screening. Any patient who tests positive for mental illness during the initial screening will be scheduled for follow up treatment, while those who test negative are advised to reach out to the clinic if their circumstances change. Research has shown that there is underutilization of mental health services by people with refugee background. (Satinsky, 2019 p12).

Most of those who are admitted into the United States through the refugee resettlement program experienced war and other traumatizing circumstances before moving to the United States. Although resettlement is a good way of helping refugees regain a good, if not better life, studies have shown that "during resettlement, refugees experience changes in personal and community relations that can have dramatic effects on their sense of self and, in turn, well-being" (Bergquist et al., 2019, p.1). As a result of their exposure to various circumstances -in their native countries-, this population is more prone to health issues including mental illness compared to the general population in the United States.

Further research showed that there is an increased risk of mental health issues for people with refugee background, because of displacement from their homes. The effect can cause psychological illness at a level higher than the general population including major depressive disorder (MDD) and posttraumatic stress disorder (PTSD) (Hynie, 2018).

Mental health affects certain members of families with refugee backgrounds across all ages. Young people may be more resilient when it comes to physical health but are not immune to mental illness. Family disruption causing internal displacement or resettlement into a foreign country is one of the triggers for mental illness. In their effort to address health disparities in mental health of refugee children and adolescents, Betancourt et al, (2015) revealed that "The prevalence of posttraumatic stress disorder and depression among resettled refugee children is estimated to be as high as 54% and 30%, respectively, compared with an estimated 5% (posttraumatic stress disorder) and 11% (depression) of youths with these disorders in the general population" (Betancourt et al., 2015).

Studies have shown that people with refugee backgrounds all over the world, underutilize mental health services despite the high prevalence of mental illness among their populations compared to the general population. "Studies assessing utilization and access to mental health and psychosocial support (MHPSS) services in Europe, showed evidence that refugees and asylum seekers receive inadequate mental health and psychosocial support (MHPSS) relative to need" (Satinsky, 2019, p. 862). This underutilization can be explained by several factors including language barriers, differences in symptom expression, discrepancies between patient and provider service expectations, lack of awareness of services, stigma, and cultural differences in help seeking (Satinsky, 2019 p. 862).

A similar study in Canada found that immigrants and other ethnic minorities have a lower representation in the mental health care system and are known to underutilize mental health services. Some of the variables causing underutilization of mental health services by the refugees include age, place of origin, educational level, marital status, English speaking skills, transportation problem, long waiting list to get medical care, and preferences for one's own cultural services among others (Thomson, Chaze, George, & Guruge, 2015).

CHAPTER 3 - METHOD

Study Design

This study aimed at providing information on the barriers of mental health services for people with refugee background in Nebraska through a survey administered to the participants either by phone or in person. The survey responses were analyzed using quantitative methods.

Study Sample

A convenient sample was used from CHI. Eligible participants were any individuals with a refugee background who went through CHI for their health screening in the past 3 years. Participants must have been 19 years or older. A statement of consent was read to all participants before participation (see Appendix B). All participants were residents of Douglas County, Nebraska.

Recruitment

Participants were selected from a list of refugees who had received services from CHI University Campus clinic. Participant's contact information was accessed from the clinic data base. An interpreter service was provided by CHI and each participant was spoken to via interpreter in a language he or she understood. The average time spent was between 30 to 35

minutes except if participants declined to answer some questions which reduced the overall time spent. At the time of data analysis, there were responses from 30 participants.

Statistical Analysis

General descriptive statistics were reported, including sociodemographic information. All categorical variables were summarized by frequencies and percentages and bar and pie plots. Comparisons were made between participant demographic characteristics and mental health factors to identify factors associated with mental health awareness and mental health service utilizations. For two categorical variables, the Chi-square test of association or the Fisher's exact test was used as appropriate. P-values less than 0.05 will was considered statistically significant. Both SPSS and Excel software were used for data analyses.

Survey Instrument

The survey instrument for this research was designed by this researcher. However, some of the answer options of the first question (evaluating knowledge of mental health) were adapted from the generalized anxiety disorder (GAD 7) and patient health questionnaire (PHQ 9) assessment tools.

(See Appendix A for a link to the tools)

CHAPTER 4 – RESULTS

Participants' Sociodemographic Characteristics

As illustrated in Table 1, most participants were from Asia (Burma=11, Nepal=2, Bhutanese=2, Thais=1, Afghan=3, and Syrians=2). Gender representation was slightly higher on the male side compared to the female (53% and 47%, respectively). 73% of participants were married and 69% had less than high school education or no formal education.

Table 1. Participant Characteristics

Variable	**#**	**%**
Country of Origin		
Asia	23	77**%**
Africa	6	20**%**
Europe	1	3 **%**
Age group		
18 – 30 years	7	23**%**
31 – 40 years	9	30**%**
41 – 50 years	9	30**%**
51 – 65 years	5	17**%**
Gender		
Female	14	47**%**
Male	16	53**%**
Marital Status		
Married	22	73**%**
Other	8	27**%**
Education		
No education	5	17**%**
Less than High School	15	52**%**
High School and above	9	31**%**
Knowledge of mental illness		
Yes	16	53%
No	14	47%

NB: **Asia** consists of Burma, Nepal, Afghanistan, Bhutan, Syria, and Thailand,
Africa consist of D.R. Congo, Ethiopia, and Tanzania.
Europe consists of only Ukraine
Highschool and above consist of vocational training and bachelor's degree.
Other (in the marital status) consists of widowed, separated, divorced, and never married.

Table 2 shows 80% of participants had prior knowledge of mental health and only 28% utilized mental health services. There was missing data in the utilization of mental health services. There was no significant association between knowledge of mental illness and utilization of mental health services.

According to Figure 1, 81% of males and 79% of females had knowledge of mental health.

Table 2. Mental Health Knowledge and Utilization

Variable	#	%
Knowledge of mental illness		
No	6	20%
Yes	24	80%
Total	**30**	**100%**
Utilization of mental health services		
No	21	72%
Yes	8	28%
Total	**29**	**100%**

Figure 1. Mental Health Knowledge by Gender

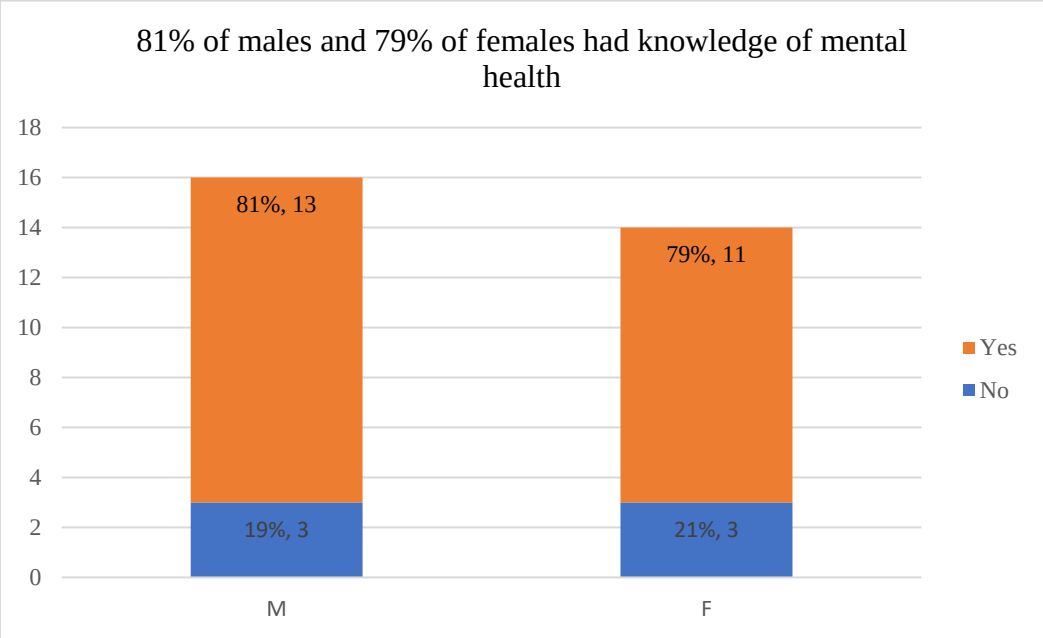


Table 3 shows no association between knowledge of mental illness and utilization **(P-value=0.343)**. Most participants confirmed knowledge of mental illness but only 28% utilized mental health services.

Table 3. Association of Mental Health Utilization and Knowledge.

Sought Mental Health Services	Mental Health Knowledge	
	No	Yes
No	5 (83%)	16 (70%)
Yes	1 (16%)	7 (30%)
Total	**6(100%)**	**23 (100%)**

P-value=**0.343**

Table 4 indicates that there was a significant association between age and utilization of mental health services **(P-value 0.012)**. None of the remaining factors (gender, continent, and education) had any significant association with mental health services utilization. There was no significant association with any of the factors (Table 5) with knowledge of mental health.

Table 4. Factors Associated with Mental Health Utilization and Knowledge

Variable	**Mental Health Services**		**P-value***
	No (n=21; 72%)	Yes (n=8; 28%)	
Gender			
Female	9 (43%)	4 (50%)	0.303
Male	12 (57%)	4 (50%)	
Age category			
18-50 years	20 (95%)	4 (50%)	0.012
51-65 years	1 (5%)	4 (50%)	
Continent			
Asia	16 (76%)	6 (75%)	0.365
Other	5 (24%)	2 (25%)	
Education Level			
High school and above	7 (33%)	3 (38%)	0.102
Less than high school	11 (52%)	3 (38%)	
No education	3 (14%)	2 (25%)	

*Fisher's exact test since at least 25% of the cells have expected counts less than 5.

Table 5. Factors Associated with Knowledge of Mental Illness

Variable	Knowledge of mental illness		P-value*
	No (n=6; 20%)	Yes (n=24; 80%)	
Gender			
Femal	3 (50%)	11 (46%)	0.343
Male	3 (50%)	13 (54%)	
Age category			
18-50	5 (83%)	20 (83%)	0.447
51-65	1 (17%)	4 (17%)	
Continent			
Asia	6 (100%)	17 (71%)	0.170
Other	0 (0%)	7 (29%)	
Education Level			
High school and above	3 (50%)	7 (29%)	0.092
Less than High school	3 (50%)	12 (50%)	
No education	0 (0%)	5 (20%)	

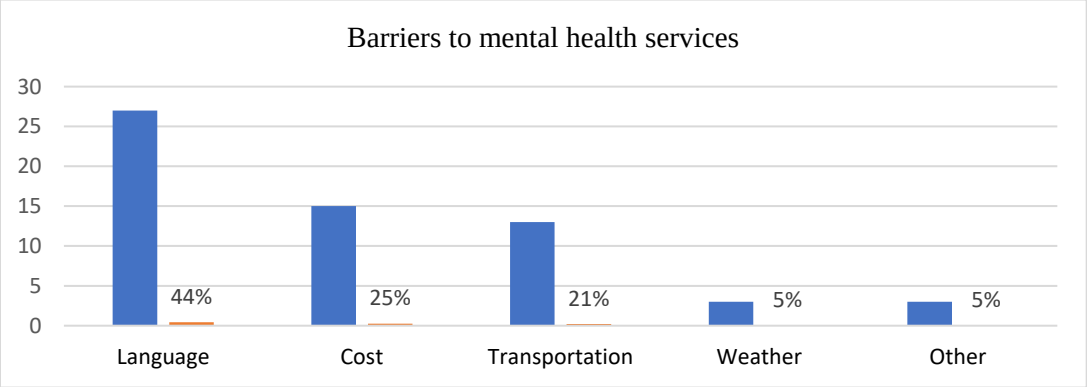
Table 6. Perceived Barriers for Mental Health Utilization

Barrier	#	%
Language	27	44%
Cost	15	25%
Transportation	13	21%
Weather	3	5%
Other	3	5%
TOTAL	**61**	**100%**

NB: All participants were asked about barriers and allowed to choose multiple answers.

"Other" items consist of cultural differences, directions to clinic, and limited sessions for mental health therapy sessions.

Figure 2.



As shown in Table 7, only 9 participants mentioned a type of support that was needed which corresponds with the low amount of mental health services utilization (28%). Interpretation services provided to facilitate communication for people with refugee background was classified as the main support (78%).

Table 7. Support for the Utilization of Mental Health Services

Support	**Frequency**	**%**
Interpreter	7	78%
Medicaid	1	11%
Financial	1	11%
Total	**9**	**100%**

As indicated in Table 8, all participants provided at least one answer, and some provided multiple answers to this question. Insurance coverage (Medicaid) which is provided to all refugees up on arrival, was identified as the main solution (38%). Telemedicine, the latest technologies introduced into the healthcare system, was the second highly rated solution (21%).

As shown in Table 9, three participants declined to answer this question. However, 81% of the participants indicated interest in learning more about mental health services. However, this study found no outreach program in place that will create an opportunity for refugees to learn more about mental health.

Table 8. Solutions to Problems Faced During the Utilization of Mental Health Services.

Solution	**#**	**%**
Insurance	16	38%
Telemedicine	9	21%
Education on MH	6	14%
Interpreter	5	12%
Cultural competency	4	10%
Other	2	4%
Total	**42**	**100%**

"Other" category consists of transportation and tutoring for children

Table 9. Participants' Interest in Learning More About Mental Health

Interest	**#**	**%**
Yes	22	81%
No	5	19%
Total	**27**	**100%**

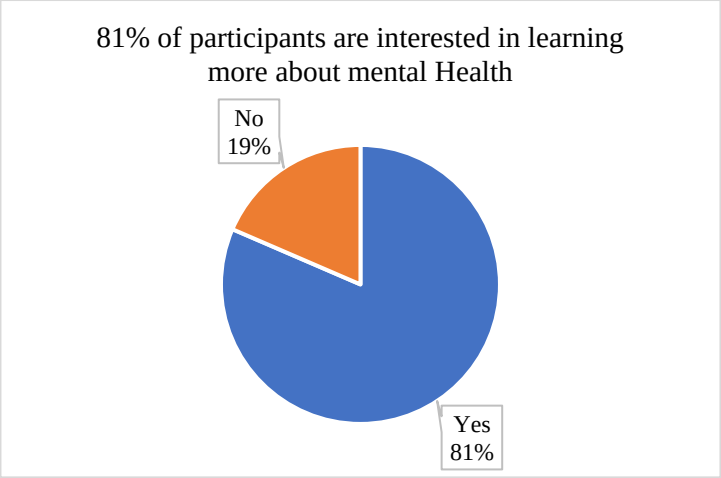


FIG 3.

CHAPTER 5 – DISCUSSION

The aims of this study were to identify barriers associated with mental health services and possible solutions, and factors promoting underutilization and supportive services for patients with refugee background who are seeking mental health services. Some of the findings from this study indicate that there is a significant association between age and mental health utilization (0.012). Participants between the ages of 31 to 50 years were the most affected. Various factors could have caused this significant association. Access to mental health screening was accessible for adults more than the youths. Adults have a better understanding of their health condition than youth. Another factor that could contribute to the significance association between age and mental illness could be life stressors caused by socio-economic situations. This finding implies that there are more adults needing mental health than youths. If adult refugees especially parents, do not receive adequate mental health services, parenting and caring for their children will be very difficult for them. This will widen further the gap of mental health disparity in the community.

On the other hand, there was no association between having knowledge of mental health and utilization of mental health services. In addition, 81% of all participants had interest in learning more about mental health. The most common barrier to mental health services identified in this study was language barrier as also discussed in the literatures. A small portion of participants (n=9) identified translation services currently provided as helpful.

In this study, participants identified potential solutions to the barriers to mental health services. Insurance (38%) and telemedicine (21%) were the two highly suggested solutions. Normally, it takes time for refugees to find job that can offer them insurance as most of them are not educated (17%) and have less than high school education (52%). Without having a good job with decent pay, they cannot afford to pay for health care. Using telemedicine is an effective way to minimize cost and promote access to mental health services. It will enable parents who do not have babysitters, transportation, or other means of getting to the hospital, get access to services at the comfort of their home.

In this study, all participants were provided interpreters to translate survey questions into their own language during the survey. All the participants were living in Douglas County and most of them had firsthand experience of some of the barriers and solutions identified.

STRENGTHS AND LIMITATIONS

This study identified and gathered information based on the perspective of people with refugee background. This makes the information gathered reliable and factual in informing services to this population. Hospitals and clinics can use this information to improve their services for this population. This study also used information from literature to compare study findings to the current literature.

One major limitation of this study was language barrier. Participants did not speak English and the researcher did not understand their languages. Some of the terms and expressions may not have translated exactly into certain languages. Another limitation was the inability of the researcher to determine why most participants did not use mental health services. Although, 81% of males and 79% of females had knowledge of mental health, only 28% sought mental health services. Researcher was unable to establish among the 72% who did not utilize mental health services, how many of them needed mental health services and were unable to use it or did not need it.

Another limitation of this study is the small sample size and limited diversification. 77% of participants were Asians and 20% were Africans. This does not represent all the refugee population in Douglas County. Hence, the results of this research cannot be generalized.

RECOMMENDATIONS

This study revealed that age is associated with mental health. Mental health providers and policy makers should increase effort to provide tailored mental health services for refugee adults and address barriers hindering access to mental health for adult people with refugee background.

I recommend that CHI University Campus clinic initiate an outreach program to reach out to all refugees especially those who test negative for mental health during their initial screening and provide them with more information about mental health and access to mental health services. We note that subjects in this study are all adult refugees. Further studies with young adults and adolescent refugees should be conducted to review the determinants of mental health for children of people with refugee background.

Furthermore, this study revealed that participants regard the provision of insurance coverage and the use of technology in mental health services (telemedicine) as the most important solutions. CHI should collaborate with other institutions such as, the Refugee Empowerment Center, and create centers that have staff that can assist refugees with applications for health insurance and have technological tools that refugees can use for telemedicine purposes. Such centers will promote access to mental health services for people with refugee background in Douglas County.

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Appendix A

The link below leads to the Gad 7 and PHQ 9 mental health assessment tools:

https://www.torbayandsouthdevon.nhs.uk/uploads/score-sheet-gad-7-anxiety-and-phq-9-depression.pdf

Appendix B

Consent Seeking Information

I am a student at the University of Nebraska Medical Center college of public health. I am conducting a study for my capstone which is one of the requirements for students to graduate. I am in the process of looking for participants who can help me answer my questions. There will be a total of 30 participants in this study. You have the right to decline, skip any question you do not want to answer or stop answering entirely if you change your mind with no consequences. The questions are about mental health services, and the survey will last between 30 min to an hour. Would you like to participate? Before we begin, do you have any questions for me?

Appendix C

Survey Questions

1. Demographic

A. What is your age range?

……Under 18, ……..18 to 40, …….41 to 65, …….66 and above

B. How long have you lived in the United States? ……months/years

C. Gender? ……..Male, …….Female, ……other

D. What country is home for you?

……. Country ..……..City, ……..Village, ……Camp

E. Race and Ethnicity

……Black African, …….Arab, …….Asian ……European, ……Other

F. What is your native language? ……

G. Marital Status?

……..Married, ……..Separated ……Divorced /Widowed, …….Never married,

H. Education

What is your highest level of education?

....Less than high school …..High school ……..GED ……Vocational training/certification

……..Bachelors ..…..Masters …..PHD

2. Knowledge of mental illness

1. Do you understand what is meant by mental illness? ……Yes …….No

   If Yes, have you experienced or known someone who has any of these symptoms of mental illness?

……Feeling sad or Depressed ……Confused thinking ……inability to concentrate ……Excessive fears or worries ……..Restlessness ……Extreme mood changes ……Problems sleeping ……Delusions, Paranoia, or Hallucinations ……Suicidal thinking ……Lack of appetite

…….

2. Have you sought mental health treatment since you came to Nebraska? …..Yes …….No

   2A- If Yes, in what format? (choose all that apply)

   ……Counselling/Psychotherapy, ……medication, ……Hospitalization ..…….. Support groups ……..Inpatient/residential ……..Complementary and Alternative Treatment ……..Other

   i- What barriers did you face in the process?

   …….. communication/language, …… lack of insurance or underinsurance, ……access to providers, ……...lack of mobility/transportation, ……cultural difference/not validated, ……..…… lack of information ……..stigma, ……..lack of trust, ……others.

ii- What supports were helpful to you in the process?

…… language /interpreter services, …… financial support, ……. transportation, ……Other

2B- ….. If No, do you know any of your family member or other refugee person who have mental health issue? …….Yes …….No

i- If you were to seek mental health services, which of the following problems might apply to you? (choose all that apply)

….. Cost …...Language barrier, …..transportation …..weather ..… cultural (stigma) ……. any other.

3- What can you suggest as solutions to these problems?

……provide information/education about mental health, ……provide insurance coverage, …….more cultural competency training for providers, ……...provide tools for telemedicine, ……Others (list as many as you can)

4- Are you interested to learn more about mental illness? ……Yes, ……..No

Appendix D
IRB WAIVER

Below is the email I received from IRB

Mustapha

Per the information provided in the questionnaire #330; dated March 25, 2021 where you doing a survey for patients and CHI who have a refugee background where you only plan to present back to CHI and UNMC for your capstone, the Office of Regulatory Affairs (ORA) determined this project does not constitute human subject research as defined at 45CFR46.102. Therefore, it is not subject to the federal regulations. No further action is required. No Application needs to be submitted.

Please be advised that should anything change which would result in the project meeting the definition of human subject research, the IRB must be notified before any further research activity continues.

Should you have any questions please do not hesitate to contact the Office of Regulatory Affairs at 559-6463.

Sincerely,
Gail